

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



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V.S. AT 5:56  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12568 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1256<sup>SA</sup>

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>Dalton Clubhouse</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WARREN</b>		First <b>FREDERICK</b>	Middle <b>BRUNNER</b>
4. DATE OF DEATH <b>November 2 1958</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1941</b>
9. AGE (In years last birthday) <b>16 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ellicott City, Md.</b>	
13. FATHER'S NAME <b>Henry E. Brunner</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth S. Hill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elizabeth Brunner</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>919.6</b>		DUE TO <b>Gunshot wound of head and neck</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Accidentally shot by brother</b>	
20c. TIME OF INJURY Hour <b>10:15</b> a.m.	Month, Day, Year <b>11/2 1958</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Clubhouse</b>
20f. (City or town) <b>Ellicott City</b>	(County) <b>Howard</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>	DATE SIGNED <b>Nov. 3, 1958</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-6-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Christ Church</b>	22d. LOCATION (City, town, or county) (State) <b>Guilford, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Caroline S. Kraske</i>

SEARCHED - INDEXED - SERIALIZED - FILED  
MAY 10 1969 BY SP-274 MARY JACKSON 8603

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12569

## CERTIFICATE OF DEATH

Reg. Dist. No.

12568

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>HOWARD</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLIOTT CITY</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLIOTT CITY</b>		d. STREET ADDRESS <b>1 WOODLAND ROAD</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WOODLAND ROAD</b>				d. STREET ADDRESS <b>1 WOODLAND ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>ANNIE CLEMENT</b>		First	Middle	Last	4. DATE OF DEATH <b>Nov. 9, 1958</b>	Month	Day	Year							
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 20 1882</b>		9. AGE (In years lost birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <b>SABARD RICH</b>		14. MOTHER'S MAIDEN NAME <b>TINE FINGAR</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>LUTHER CLEMENTS, ELLIOTT CITY MD</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebro-vascular accident		Hypertensive-Arteriosclerotic Cardio-vascular disease						INTERVAL BETWEEN ONSET AND DEATH <b>6 da</b>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>46 Church Road</b>		20f. (City or town) <b>ELLICOTT CITY</b>		(County) <b>Md.</b>		(State)	
21. I certify that I attended the deceased from <b>Nov. 5, 1958</b> to <b>Nov. 9, 1958</b> , that I last saw the deceased alive on <b>Nov. 5, 1958</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>46 Church Road</b>		DATE SIGNED <b>11-9-58</b>			
ACTUAL SIGNATURE <b>Thomas J. Herbert</b>		PHYSICIAN'S NAME (Type) <b>46 Church Road</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-11-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>GOOD SHEPHERD</b>		22d. LOCATION (City, town, or county) <b>ELLICOTT CITY</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. HIGGINBOTHOMY, ELLICOTT CITY MD</b>		ADDRESS <b>46 Church Road</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kraus</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DESIGN

DATE FILED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12570

## CERTIFICATE OF DEATH

12569

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
				o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Woodbine		c. LENGTH OF STAY IN 1b 60 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Woodbine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Carrs Mill Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First RIGGS	Middle DORSEY	4. DATE OF DEATH Nov. 22, 1958	Month Day Year
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 8-9-1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY own		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Augustus Riggs Dorsey		14. MOTHER'S MAIDEN NAME Fannie M. Griffith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Byron C. Dorsey, Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 33IX		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Arteriosclerosis, Advanced-	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mt. Airy	(County) (State) Md.
21. I certify that I attended the deceased from <u>Nov 10, 1958</u> to <u>Nov 22, 1958</u> , that I last saw the deceased alive on <u>Nov 21, 1958</u> , and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	<u>C. M. Van Poole</u>		<u>M.D.</u>	ADDRESS (Street, city or town, state) <u>Mt. Airy, Md.</u>	DATE SIGNED <u>11-22-58</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-25-1958	22c. NAME OF CEMETERY OR CREMATORIAL Pine Grove	22d. LOCATION (City, town, or county) Mt. Airy, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,	ADDRESS Winfield, Md.	24a. REC'D BY REGISTRAR NOV 28 '58	24b. REGISTRAR'S SIGNATURE <u>Charles L. Krause</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12571

## CERTIFICATE OF DEATH

Reg. Dist. No.

12570

1. PLACE OF DEATH a. COUNTY <u>Hanover</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Hanover</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scaggsville</u>		c. LENGTH OF STAY IN 1b <u>16 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scaggsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Columbia Rd</u>			d. STREET ADDRESS <u>Old Columbia Road</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>William</u>	Middle <u>J. Dustin'</u>	Last <u></u>	4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>January 17 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Silas Dustin'</u>			14. MOTHER'S MAIDEN NAME <u>Mary Start</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT <u>Wm. Dustin, Scaggsville Md</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>arteri aneurysm rupture</u>			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>		
(b) DUE TO <u>arteriosclerosis</u>			<u>years</u>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>52</u> , to <u>Nov 17, 1958</u> , that I last saw the deceased alive on <u>Nov 17, 1958</u> , and that death occurred at <u>4 1/2 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. R. Buell</u> ADDRESS <u>402 Main Street</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>John R. Buell, M. D.</u>			Laurel, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/58</u>		22c. NAME OF CEMETERY OR CREMATORIY <u>Emmanuel Cem</u>	
22d. LOCATION (City, town, or county) <u>Scaggsville Md</u>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dewitt Hanaldan Laurel Md</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 24 1958</u>		
			24b. REGISTRAR'S SIGNATURE <u>Charles S. Krause</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

The registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

STATE OF CALIFORNIA  
DEPARTMENT OF CHANCERY  
CERTIFICATE OF DEATH

Deceased's Name	Date of Birth	Place of Birth	Age at Death	Sex	Color of Hair	Color of Eyes	Occupation	Employer	Residence	City	County	State	Country	Religion	Marital Status	Spouse's Name	Children	Other
John Doe	1880-01-01	New York City	75	M	Black	Hazel	Retired	N/A	123 Main Street	Los Angeles	Los Angeles	California	United States	Protestant	Married	Jane Doe	4	None
I declare under penalty of perjury that the information contained in this certificate is true and correct.																		
Signed: John Doe																		
Date: 10/20/2023																		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

## CERTIFICATE OF DEATH

Reg. Dist. No.

12571

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Md</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ellicott City</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Elioak</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>FRANK</b>	Middle <b>EDSON</b>	Last	4. DATE OF DEATH	Month <b>Nov. 17, 1958</b>	Day Year <b>19 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1886</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <b>0</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>		
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Wm. Edson, 610 Edmonson Ave. Catonsville 28, Md</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>(b)</b>		Acute Pulmonary Edema cardiac Decompensation <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) <b>Ellicott City</b>	(County) <b>Baltimore</b>	(State) <b>Md</b>		
21. I certify that I attended the deceased from <b>1957</b> , 19, to <b>11-17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-17-58</b> , 19, and that death occurred at <b>10 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>P V Thorpe</b> M.D. ADDRESS (Street, city or town, state) <b>Ellicott City</b> DATE SIGNED <b>11-19-58</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Johns Lutheran</b>	22d. LOCATION (City, town, or county) <b>Pfeifers Corner, Md</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>NOV 24 58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Paul</b>				
			DATE					

PROPOSAL—PLAN TO THE MASS STATE BOARD OF

TRAD TO STATEHOOD

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	80337	80338	80339	80340	80341	80342	80343	80344	80345	80346	80347	80348	80349	80350	80351	80352	80353	80354	80355	80356	80357	80358	80359	80360	80361	80362	80363	80364	80365	80366	80367	80368	80369	80370	80371	80372	80373	80374	80375	80376	80377	80378	80379	80380	80381	80382	80383	80384	80385	80386	80387	80388	80389	80390	80391	80392	80393	80394	80395	80396	80397	80398	80399	80400	80401	80402	80403	80404	80405	80406	80407	80408	80409	80410	80411	80412	80413	80414	80415	80416	80417	80418	80419	80420	80421	80422	80423	80424	80425	80426	80427	80428	80429	80430	80431	80432	80433	80434	80435	80436	80437	80438	80439	80440	80441	80442	80443	80444	80445	80446	80447	80448	80449	80450	80451	80452	80453	80454	80455	80456	80457	80458	80459	80460	80461	80462	80463	80464	80465	80466	80467	80468	80469	80470	80471	80472	80473	80474	80475	80476	80477	80478	80479	80480	80481	80482	80483	80484	80485	80486	80487	80488	80489	80490	80491	80492	80493	80494	80495	80496	80497	80498	80499	80500	80501	80502	80503	80504	80505	80506	80507	80508	80509	80510	80511	80512	80513	80514	80515	80516	80517	80518	80519	80520	80521	80522	80523	80524	80525	80526	80527	80528	80529	80530	80531	80532	80533	80534	80535	80536	80537	80538	80539	80540	80541	80542	80543	80544	80545	80546	80547	80548	80549	80550	80551	80552	80553	80554	80555	80556	80557	80558	80559	80560	80561	80562	80563	80564	80565	80566	80567	80568	80569	80570	80571	80572	80573	80574	80575	80576	80577	80578	80579	80580	80581	80582	80583	80584	80585	80586	80587	80588	80589	80590	80591	80592	80593	80594	80595	80596	80597	80598	80599	80600	80601	80602	80603	80604	80605	80606	80607	80608	80609</

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 File No. 11-7-58 et

12573

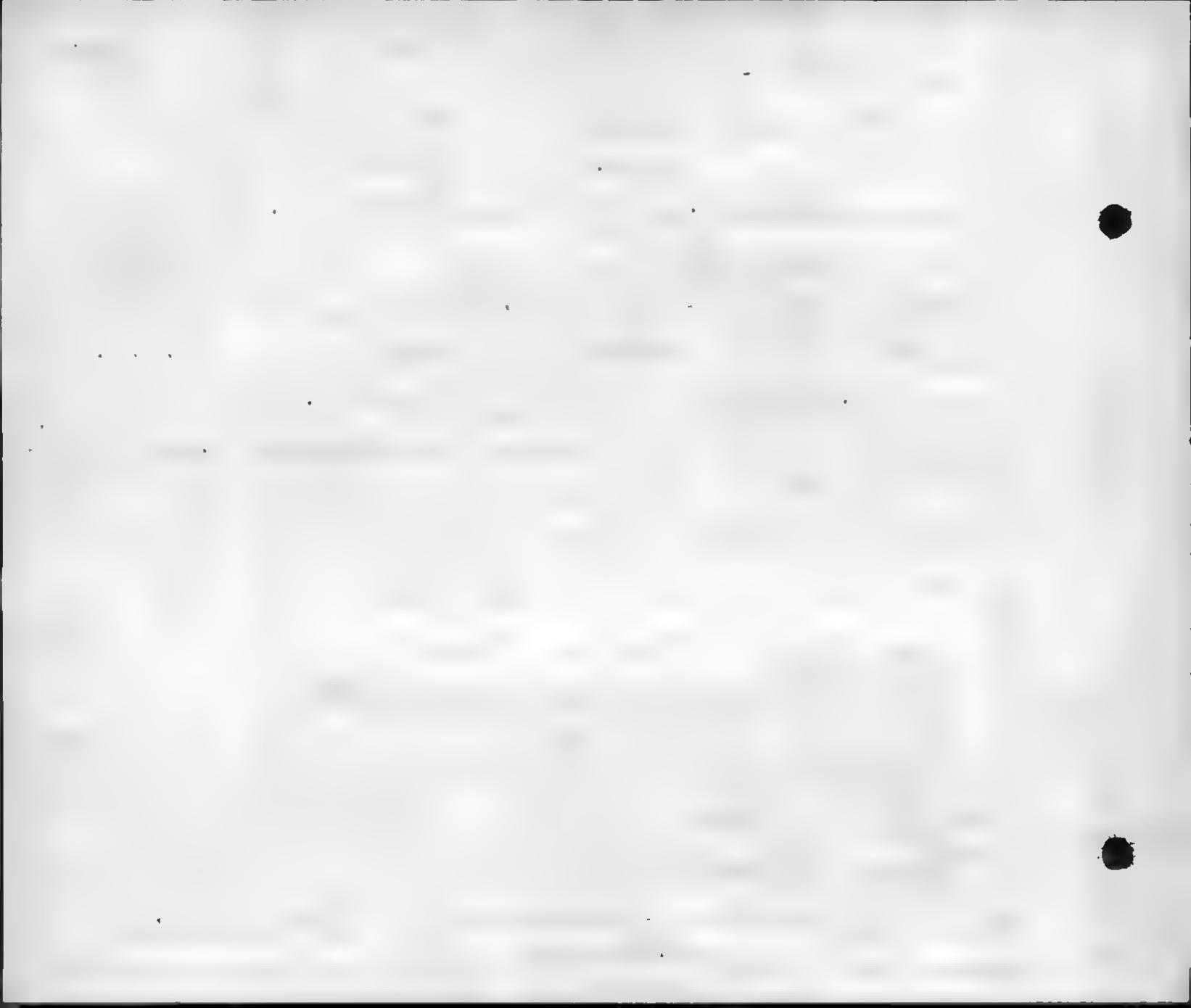
## CERTIFICATE OF DEATH

Reg. Dist. No. 12572

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <b>Howard</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE <b>Maryland</b>		b COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>80 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>97 College Ave.</b>		d. STREET ADDRESS <b>97 College Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CAROLINE GRIMES</b>		First	Middle	Last	4. DATE OF DEATH <b>November 2, 1958</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 20, 1871</b>	9. AGE (In years last birthday) <b>86 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>John F. Reus</b>				14. MOTHER'S MAIDEN NAME <b>Dorothea L. Kroger</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Dora Grimes 97 College Ave. Ellicott City,</b>		Address <b>Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cardio-vascular disease</i>				INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Arteriosclerosis</i>				<b>15 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Nov. 10, 1958</b> to <b>Nov. 2, 1958</b> , that I last saw the deceased alive on <b>Nov. 2, 1958</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. M. Henrich</b>		ADDRESS (Street, city or town, state) <b>203-Towpath Ave - Baltimore - 28.</b>						DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Johns Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		ADDRESS <b>12573</b>		24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>J. E. Kline</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12573

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Howard</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <i>Elliot City</i>		c. LENGTH OF STAY IN 1b <i>RFD #2</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elliot City P.O.</i>		d. STREET ADDRESS <i>RFD #2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RFD #2</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>JAMES H. KAehler</i>		First <i>J</i>	Middle <i>A</i>	Last <i>KAehler</i>	4. DATE OF DEATH <i>11 9 1958</i>	Month <i>11</i>	Day <i>9</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3/3/89</i>	9. AGE (In years last birthday) yr. <i>69</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>	13. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salomon ret. lumber</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph W. KAehler</i>		14. MOTHER'S MAIDEN NAME <i>Sarah J. Devine</i>		Address <i>Mrs. Agnes KAehler</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Dr. James H. KAehler</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Injury - cerebral</i>		DUE TO <i>General Arteriosclerosis</i>		(b) <i>General Arteriosclerosis</i>		(c)		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>33 N Frederick St</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Nov 3, 1958</i> to <i>11/10 1958</i> that I last saw the deceased alive on <i>11/10 1958</i> , and that death occurred at <i>2:10 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>33 N Frederick St</i>		DATE SIGNED <i>11/10/58</i>		
ACTUAL SIGNATURE <i>James H. KAehler</i>								
PHYSICIAN'S NAME (Type) <i>James H. KAehler</i>								
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/12/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cathedral</i>		22d. LOCATION (City, town or county) <i>Baltimore</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Ralph Johnson</i>		ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR DATE NOV 13 '58		24b. REGISTRAR'S SIGNATURE <i>C. E. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12575

## CERTIFICATE OF DEATH

Reg. Dist. No.

12574

1. PLACE OF DEATH o COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) o. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>		b. COUNTY <i>Howard</i>	
c. LENGTH OF STAY IN 1b <i>20 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Elizabeth</i>	Last <i>Knap</i>	4. DATE OF DEATH Month <i>November</i> Day <i>3</i> Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OF HAIR <i>Wht</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 16, 1901</i>	9. AGE (In years, lost birthday) <i>57 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hausfrau</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Name</i>		11. BIRTHPLACE (State or foreign country) <i>Ithaca N.Y.</i>
13. FATHER'S NAME <i>Henry Patula</i>		14. MOTHER'S MAIDEN NAME <i>Mary Sedarka</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Generalized carcinomatosis</i> DUE TO <i>15m</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Carcinoma of liver</i> DUE TO <i>2 yrs.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>9 mos.</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18.) <i>None</i>
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Laurel</i> (County) <i>Md</i> (State) <i>None</i>

21. I certify that I attended the deceased from <i>10/1/1958</i> to <i>10/16/1958</i> , that I last saw the deceased alive on <i>10/3/1958</i> , and that death occurred at <i>Laurel Md</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>None</i>	DATE SIGNED <i>11/6/58</i>
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ACTUAL SIGNATURE <i>A. V. Warren</i>	M.D. <i>Dr. A. V. Warren</i>	PHYSICIAN'S NAME (Type) <i>A. V. WARREN</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 6, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary Cemetery</i>	22d. LOCATION (City, town, or county) <i>Laurel</i> (State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>He Witt</i>	ADDRESS <i>Laurel Maryland Laurel Md</i>	24a. REC'D BY REGISTRAR <i>NOV 10 1958</i>	24b. REGISTRAR'S SIGNATURE <i>C. W. &amp; K. Knapp</i>



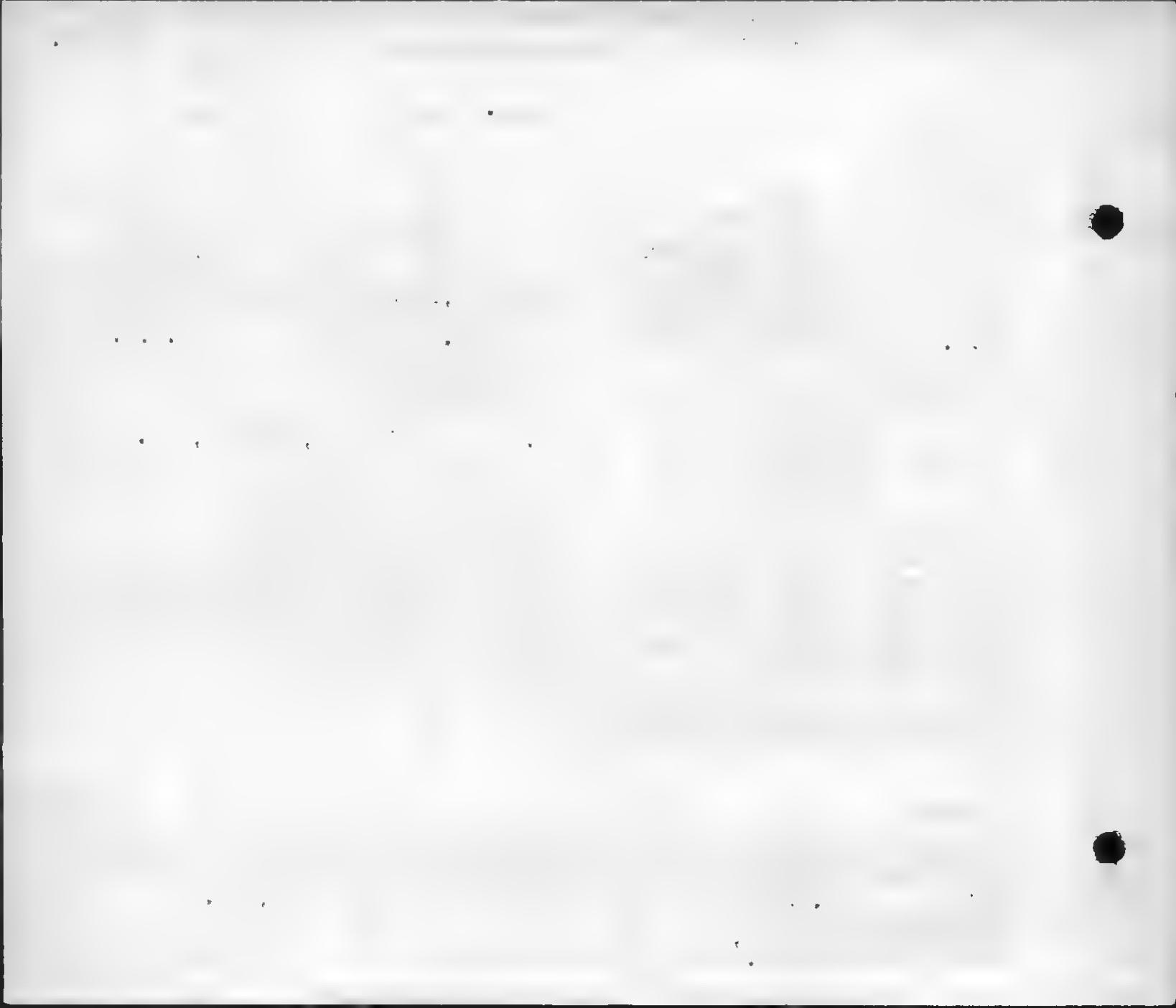
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then place carbon paper, Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12576 CERTIFICATE OF DEATH**

12575  
Reg. Dist. No.

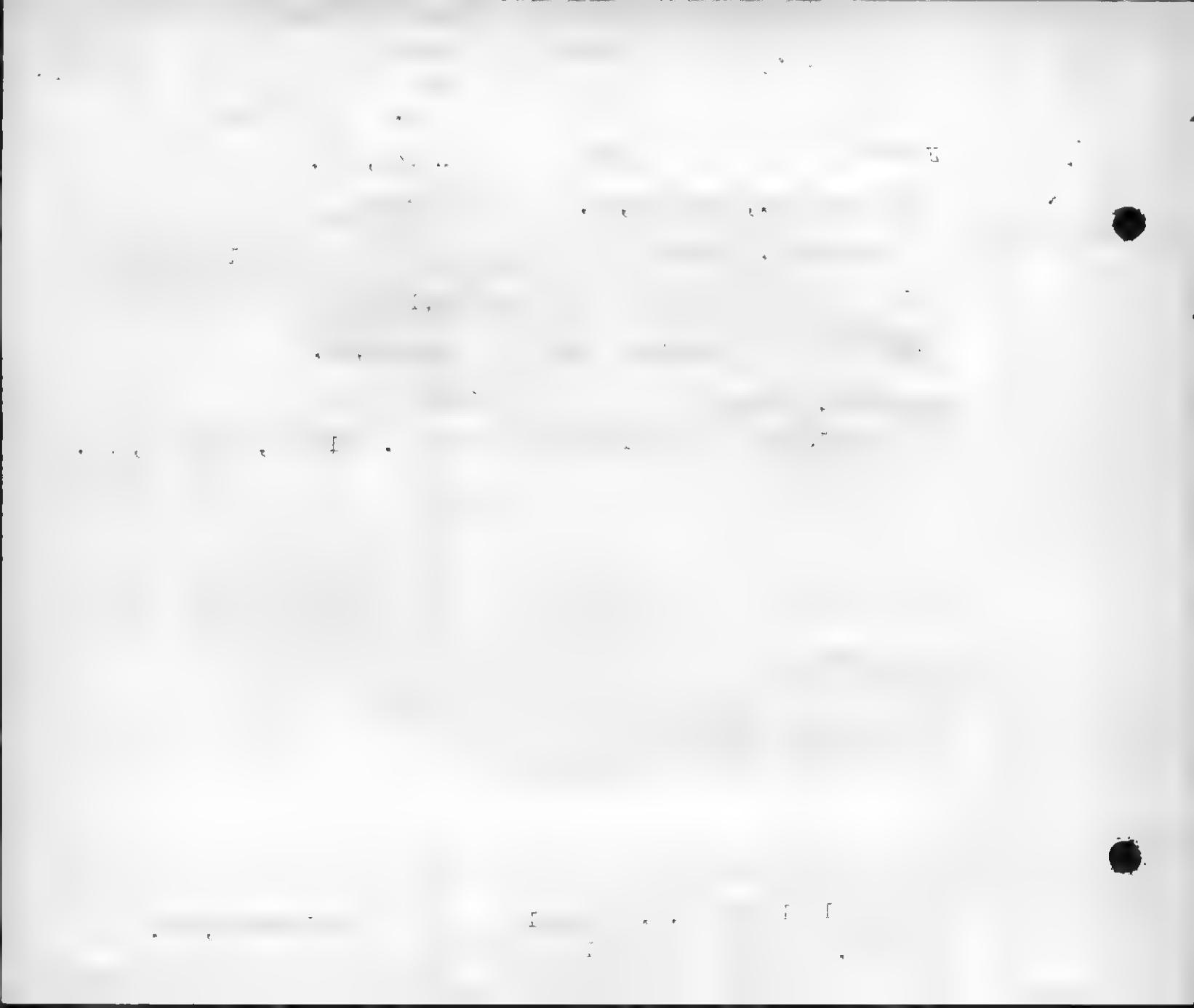
1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenelg</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simons Rest Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary Rosseter</b>	Middle	Last	4. DATE OF DEATH	Month <b>NOV.</b>	Day <b>22</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1882</b>	9. AGE (In years from birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Enos Jones</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Haywarth</b>		Address <b>Mrs. Helen Weissman, Glenelg, Md.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic heart disease</b>	
DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
						10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D.</b>		20f. (City or town) <b>CLARKSVILLE, MD</b> (County) <b>11/22/58</b> (State)	
21. I certify that I attended the deceased from <b>Aug. 12</b> , 1956, to <b>Nov. 22</b> , 1958, that I last saw the deceased alive on <b>Nov. 16</b> , 1958, and that death occurred at <b>M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles S. Whitaker</b> PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>						ADDRESS (Street, city or town, state) <b>CLARKSVILLE, MD</b> DATE SIGNED <b>11/22/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 25/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Home, 4101 Edmondson Ave.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>NOV 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12577 CERTIFICATE OF DEATH

Reg. Dist. No. 12576

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover, Md.</b>	b. COUNTY <b>Howard</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anderson Ave., Hanover, Md.</b>	e. STREET ADDRESS <b>Anderson Ave</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles M. Talbott</b>	First <b>Charles</b>	Middle <b>M.</b>	Last <b>Talbott</b>
4. DATE OF DEATH <b>11-26-58</b>	Month <b>11</b>	Day <b>26</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1888</b>
9. AGE (In years from birthday) <b>70</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	11. BIRTHPLACE (State or foreign country) <b>Hanover, Md.</b>
12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME <b>Joseph H. Talbott</b>	14. MOTHER'S MAIDEN NAME <b>Kate Ray</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>Yes</b>	16. SOCIAL SECURITY NO. <b>World War I 214-16-9799</b>	17. INFORMANT <b>Thomas F. Talbott, Hanover, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cler. Myocarditis (c) General arteriosclerosis		6 mos 5/18	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e. m. p. m.	Month <b>19</b>	Day <b>26</b>	Year <b>1958</b>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore, Md.</b>
(County) <b>Baltimore Co., Md.</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Nov 27, 1958</b> , to <b>Dec 26, 1958</b> , that I last saw the deceased alive on <b>Nov 27, 1958</b> , and that death occurred at <b>8:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B.B. Brumbaugh</b>		ADDRESS (Street, city or town, state) <b>3607 Main St., Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>B.B. Brumbaugh</b>		DATE SIGNED <b>11/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL <b>BURIAL 12-1-58</b>	22b. DATE THEREOF <b>12-1-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>U.S. National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave</b>	24a. REC'D BY REGISTRAR <b>Dec 1 '58</b>
			24b. REGISTERING SIGNATURE <b>John S. Evans</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12578

## CERTIFICATE OF DEATH

Reg. Dist. No.

12577

1. PLACE OF DEATH ■ COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb		d. STATE Md. b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaffer Nursing Home, Montgomery Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		f. STREET ADDRESS 614 Stanford Rd.	

3. NAME OF DECEASED (Type or print)		First LILLIAN	Middle B.	Last TURNER	4. DATE OF DEATH Nov. 15, 1958
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 30, 1873	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?			
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13. FATHER'S NAME John Turner	14. MOTHER'S MAIDEN NAME Hicks					
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Norman Gernand-14 Willow Lane, Ellicott City	Address P. O., Md. Ellicott City
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertension CV Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs -
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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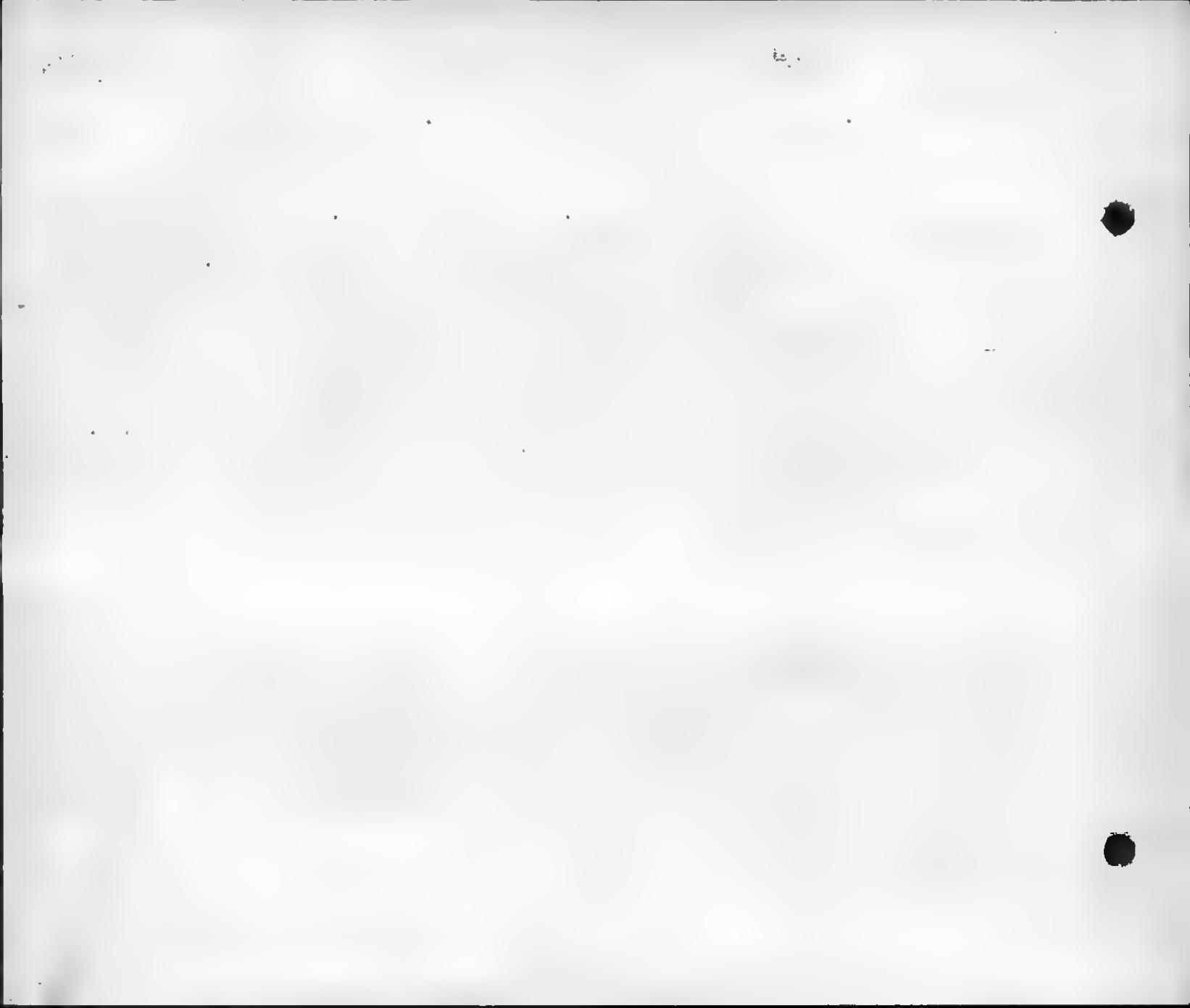
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1958, to Nov 15, 1958, that I last saw the deceased alive on Nov. 14, 1958, and that death occurred at 5 P.M., from the causes and on the date stated above.					
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ACTUAL SIGNATURE L. A. Kochman, M.D.	ADDRESS (Street, city or town, state) 1314 N. Charles St.	DATE SIGNED 11/17/58
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/19/58	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Buckner & Sons - Walter J. Buckner	ADDRESS	24a. REC'D BY REGISTRAR NOV 18 '58	24b. REGISTRAR'S SIGNATURE Walter S. Kraus
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12579

Item 11 r11mG256 12-15-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

12578

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Roland</b>	Middle <b>R.</b>	Last <b>Vane Sr.</b>
4. DATE OF DEATH	Month <b>Nov. 27,</b>	Day <b>1958</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1898</b>
9. AGE (In years (last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Ralph F. Vane</b>	
14. MOTHER'S MAIDEN NAME <b>Maude Riggins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT	Address <b>Mr. Ronald F. Vane 2109 Loudon Ave. Elkridge</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Myocardial Infarction</b>		15 hrs	
DUE TO  (c) <b>Coronary Thrombosis</b>		?	
DUE TO  (c) <b>A S CVD</b>		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-26</b> , 1958, to <b>11-27</b> , 1958, that I last saw the deceased alive on <b>11-26</b> , 1958, and that death occurred at <b>9:00</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>COLUMBIA RD 11-26-58</b>	
ACTUAL SIGNATURE <b>Peter V. Thorpe</b>		DATE SIGNED <b>11-26-58</b>	
PHYSICIAN'S NAME (Type) <b>PETER V. THORPE MD</b>		22e. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/1/1958</b>	22c. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Jones</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>C. King &amp; Kaus</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2 should be filed with the funeral director.  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 1 Film G236 12-4-58 et											
12580 CERTIFICATE OF DEATH											
Reg. Dist. No. 12579											
1. PLACE OF DEATH a. COUNTY <b>Clarksville, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Washington, D.C.</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 months</b>							
d. NAME OF HOSPITAL (If, not in hospital, give street address) OR INSTITUTION <b>Hinkson Nursing Home Clarksville, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Reginald Worlds</b>				First	Middle	Last	4. DATE OF DEATH <b>11 - 22</b>	Month	Day	Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-7-56</b>		9. AGE (in years lost birthday) <b>2 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Wilson, N.C.</b>			
13. FATHER'S NAME <b>Edward Worlds</b>				14. MOTHER'S MAIDEN NAME <b>Ernestine Edwards</b>				12. CITIZEN OF WHAT COUNTRY? Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Edward Worlds</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital cerebrospastic disorder</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Sept. 4, 1958</b> , to <b>Nov. 22, 1958</b> , that I last saw the deceased alive on <b>Nov. 18, 1958</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> , M.D. <b>Clarksville, Md.</b> ADDRESS (Street, city or town, state) <b>Wilson, N.C.</b> DATE SIGNED <b>11-22-58</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-26-58</b>				22c. NAME OF CEMETERY OR CREMATORIAL <b>Church Cemetery</b>			
22d. LOCATION (City, town, or county) <b>Wilson, N.C.</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>Heodore C. Armmung</b>				ADDRESS <b>1814 Upshur Street, N.W.</b>				24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

DEPARTMENT OF HEALTH - MEDICAL

CERTIFICATE OF DEATH

DEATH  
CERTIFICATE  
RECEIVED  
MAY 10, 1968  
BY [illegible]